NEW JERSEY STATE HEALTH BENEFITS PROGRAM COMPARISON CHART

PLAN AND TELEPHONE NUMBER	#002 TRADITIONAL[1] (800) 414-7427	#001 - NJ PLUS In-Network (800) 414-7427	#001 - NJ PLUS Out-of-Network[1] (800) 414-7427	#019 - AETNA- US HEALTHCARE Active (800) 309-2386 Retiree on Medicare (800) 345-4432	#020 CIGNA HEALTHCARE (800) 832-3211	#028 OXFORD (800) 444-6222	#033 AMERIHEALTH (800) 877-9829	#034 HEALTH NET[2] (800) 535-3647	#036 - UNIVERSITY HEALTH PLANS (800) 564-6847	PLAN AND TELEPHONE NUMBER
SERVICE AREA	Unrestricted	All of NJ and DE; parts of NY and PA	Unrestricted	All of NJ and CT; parts of NY, PA, MD, VA, IL, TX, DE, AZ, FL, IN, and NC	All of NJ, PA, NY, CT and DE: parts of AZ, CA, FL, GA, MD, NC, SC, VA, WV, and Washington DC	All of NJ; parts of NY	All of NJ and DE; parts of PA	All of NJ; parts of NY and CT	All of NJ	**SERVICE AREA**
EXPENSES COVERED										**EXPENSES COVERED**
HOSPITAL INPATIENT	100% for up to 365 days; day 366+ at 80% after deductible	100%	70% after $200 per hospital stay deductible	100%	100%	100%	100%	100%	100%	**HOSPITAL INPATIENT**
SKILLED NURSING FACILITY	100% up to 30 days per confinement	100% up to 120 days per calendar year	70% up to 60 days per calendar year	100%; unlimited days	100% up to 120 days per calendar year	100% up to 120 days per calendar year	100% up to 180 days per calendar year	100% up to 120 days per confinement	100%; unlimited days	**SKILLED NURSING FACILITY**
HOSPITAL PRE-ADMISSION TESTING	100%	100%	70% after deductible	100%	100%	100%	100%	100%	100%	**HOSPITAL PRE-ADMISSION TESTING**
PHYSICIAN (SURGERY)	Basic benefit at 100%[1]; balance at 80% after deductible	100%	70% after deductible	100%	100%	100%	100%	100%	100%	**PHYSICIAN (SURGERY)**
PHYSICIAN (OFFICE VISITS)	80% after deductible; no coverage for wellcare	100% after $5 per visit copayment	70% after deductible; no coverage for wellcare	100% after $5 per visit copayment	100% after $5 per visit copayment	100% after $5 per visit copayment	100% after $5 per visit copayment	100% after $5 per visit copayment	100% after $5 per visit copayment	**PHYSICIAN (OFFICE VISITS)**
CHIROPRACTIC	80% after deductible	100% after $5 per visit copayment; no PCP referral required	70% after deductible	100% up to 20 visits per year, $5 per visit copayment; PCP referral required	100% up to 20 visits per year, $5 per visit copayment; PCP referral required	100% after $5 per visit copayment, no visit maximum; PCP referral required	100% up to 20 visits per year, no copayment; PCP referral required	100% up to 20 visits per year, $5 per visit copayment; no referral needed	100% up to 20 visits per year, $5 per visit copayment; PCP referral required	**CHIROPRACTIC**
EMERGENCY ROOM - ACCIDENT/ NON-ACCIDENT	100% for accidental injury; 80% for non-accidental injury after deductible	100% after $25[3] copayment if reported to NJ PLUS or PCP within 48 hours	100% after $25[3] copayment if reported to NJ PLUS or PCP within 48 hours; if not reported within 48 hours, subject to deductible and coinsurance	100% after $35[3] copayment	100% after $35[3] copayment	100% after $25[3] copayment	100% after $35[3] copayment	100% after $25[3] copayment	100% after $35[3] copayment	**EMERGENCY ROOM - ACCIDENT/ NON-ACCIDENT**
DURABLE MEDICAL EQUIPMENT	80% after deductible	90% reimbursement	70% after deductible	Special $100 copayment; then 100% for rest of year	Special $100 copayment; then 100% for rest of year	Special $100 copayment; then 100% for rest of year	Special $100 copayment; then 100% for rest of year	Special $100 copayment; then 100% for rest of year	Special $100 copayment; then 100% for rest of year	**DURABLE MEDICAL EQUIPMENT**
RADIATION/ CHEMOTHERAPY OUTPATIENT	80% after deductible	100%	70% after deductible	100% after $5 copayment per office visit	100% after $5 copayment per office visit	100% after $5 copayment per office visit	100% after $5 copayment per office visit	100% after $5 copayment per office visit	100% after $5 copayment per office visit	**RADIATION/ CHEMOTHERAPY OUTPATIENT**
HOSPICE	100%	100%	70% after deductible	100%	100%	100%	100%	100%	100%	**HOSPICE**
IMMUNIZATIONS	Not covered	100% after $5 copayment per visit (except for travel)	70% for children under 12 months, after deductible	100% after $5 copayment per visit (except for travel)	100% after $5 copayment per visit (except for travel)	100% after $5 copayment per visit (except for travel)	100% after $5 copayment per visit (except for travel)	100% after $5 copayment per visit (except for travel)	100% after $5 copayment per visit (except for travel)	**IMMUNIZATIONS**
MATERNITY	Basic benefits at 100%; balance at 80% after deductible	$5 copayment for first prenatal office visit then 100% covered	70% after deductible	$5 copayment for first prenatal office visit then 100% covered	$5 copayment for first prenatal office visit then 100% covered	$5 copayment for first prenatal office visit then 100% covered	$5 copayment for first prenatal office visit then 100% covered	$5 copayment for first prenatal office visit then 100% covered	$5 copayment for first prenatal office visit then 100% covered	**MATERNITY**
PHYSICAL EXAMS	Not covered	100% after $5 per visit copayment	Not covered	100% after $5 per visit copayment	100% after $5 copayment per visit (1 visit per calendar year)	100%	100% after $5 per visit copayment	100% after $5 per visit copayment	100% after $5 per visit copayment	**PHYSICAL EXAMS**
WELL BABY	Not covered	100% after $5 per visit copayment	Not covered	100% after $5 per visit copayment	100% after $5 per visit copayment	100%	100% after $5 per visit copayment	100% after $5 per visit copayment	100% after $5 per visit copayment	**WELL BABY**
ALCOHOL ABUSE (INPATIENT)	Same as any other illness	Same as any other illness	Same as any other illness	100% detox; rehab - 28 days at 100% per occurrence	100% detox; rehab - 30 days at 100% per occurrence	100% detox and rehab	100% detox; rehab - 28 days at 100% per occurrence	100% detox; rehab - 28 days at 100% per occurrence	100% detox; rehab - 28 days at 100% per occurrence	**ALCOHOL ABUSE (INPATIENT)**
DRUG ABUSE (INPATIENT)	Same as any other illness	Same as any other illness	Same as any other illness	100% detox; rehab - 28 days at 100% per occurrence	100% detox; rehab - 30 days at 100% per occurrence	100% detox; rehab - 30 days at 100% per occurrence	100% detox; rehab - 28 days at 100% per occurrence	100% detox; rehab - 28 days at 100% per occurrence	100% detox; rehab - 28 days at 100% per occurrence	**DRUG ABUSE (INPATIENT)**
ALCOHOL ABUSE (OUTPATIENT)	Same as any other illness	100%, no visit limit	70% after deductible	100% up to 60 visits per calendar year	100% up to 60 visits per calendar year	100% up to 60 visits per calendar year	100% up to 60 visits per calendar year	100% up to 60 visits per calendar year	100% up to 60 visits per calendar year	**ALCOHOL ABUSE (OUTPATIENT)**
DRUG ABUSE (OUTPATIENT)	Same as any other illness	100%, no visit limit	70% after deductible	100% up to 60 visits per calendar year	100% up to 60 visits per calendar year	100% up to 60 visits per calendar year	100% up to 60 visits per calendar year	100% up to 60 visits per calendar year	100% up to 60 visits per calendar year	**DRUG ABUSE (OUTPATIENT)**
MENTAL HEALTH (INPATIENT)[4]	100% for 20 days per calendar year; balance at 80% after deductible up to annual/lifetime maximums	100% up to 25 days per calendar year; balance at 90% up to annual/lifetime maximums	50 days per calendar year at 50% after deductible up to annual/lifetime maximums	100% up to 35 days per calendar year	100% up to 30 days per calendar year	100% up to 30 days per calendar year	100% up to 30 days per calendar year	100% up to 30 days per calendar year	100% up to 30 days per calendar year	**MENTAL HEALTH (INPATIENT)[4]**
MENTAL HEALTH (OUTPATIENT)[4]	80% after deductible up to $10,000 annual/ $20,000 lifetime maximum	90% up to $15,000 annual/$50,000 lifetime maximum	70% after deductible up to $15,000 annual/$50,000 lifetime maximum	100% after $10 copayment per visit for up to 30 visits per calendar year	100% after $5 copayment per visit for up to 30 visits per calendar year	100% after $10 copayment per visit for up to 30 visits per calendar year	100% after $10 copayment per visit for up to 30 visits per calendar year	100% after $5 copayment per visit for up to 30 visits per calendar year	100% after $5 copayment per visit for up to 30 visits per calendar year	**MENTAL HEALTH (OUTPATIENT)[4]**
PHYSICAL / SPEECH THERAPY[5]	80% after deductible	100% after $5 per visit copayment	70% after deductible	100% after $5 copayment per visit, 60 visits per condition per year	100% after $5 copayment per visit, 60 visits per condition per year	100% after $5 copayment per visit, 60 visits per condition per year	100% after $5 copayment per visit, 60 visits per condition per year	100% after $5 copayment per visit, 60 visits per condition per year	100% after $5 copayment per visit, 60 visits per condition per year	**PHYSICAL / SPEECH THERAPY[5]**
DENTAL COVERAGE	None	None	None	None	None	Exams and cleaning for members under age 12	Exams, cleaning, and fluoride treatments for members under age 12	None	None	**DENTAL COVERAGE**
X-RAYS / LAB TESTS	80% after deductible; some charges paid at 100%	100% after $5 copayment per visit	70% after deductible	100% after $5 copayment per visit	100%	100%	100%	100%	100%	**X-RAYS / LAB TESTS**
PRESCRIPTION DRUGS[6, 7] ***Benefits for ACTIVE employees without employer prescription drug plan***	80% after deductible	90% reimbursement	70% after deductible	Generic - copayment $5 Preferred brand - $10 Other brands - $20 **Mail Order:** 90-day supply Generic - $5 Preferred brand - $15 Other brands - $25	Generic - copayment $5 Preferred brand - $10 Other brands - $20 **Mail Order:** 90-day supply Generic - $5 Preferred brand - $15 Other brands - $25	Generic - copayment $5 Preferred brand - $10 Other brands - $20 **Mail Order:** 90-day supply Generic - $15 Name brand - $30	Generic - copayment $5 Preferred brand - $10 Other brands - $20 **Mail Order:** 90-day supply Generic - $5 Preferred brand - $15 Other brands - $25	Generic - copayment $5 Preferred brand - $10 Other brands - $20 **Mail Order:** 90-day supply Generic - $5 Preferred brand - $15 Other brands - $25	Generic - copayment $5 Preferred brand - $10 Other brands - $20 **Mail Order:** 90-day supply Generic - $5 Preferred brand - $15 Other brands - $25	**PRESCRIPTION DRUGS[6, 7]** ***Benefits for ACTIVE employees without employer prescription drug plan***
PRESCRIPTION DRUGS[7] ***RETIREES***	Generic - copayment $5[8] Preferred brand - $11[8] Other brands - $21[8] **Mail Order:** 90-day supply Generic - $5[8] Preferred brand - $16[8] Other brands - $26[8]	Generic - copayment $5[8] Preferred brand - $11[8] Other brands - $21[8] **Mail Order:** 90-day supply Generic - $5[8] Preferred brand - $16[8] Other brands - $26[8]	Generic - copayment $5[8] Preferred brand - $11[8] Other brands - $21[8] **Mail Order:** 90-day supply Generic - $5[8] Preferred brand - $16[8] Other brands - $26[8]	Generic - copayment $5 Preferred brand - $10 Other brands - $20 **Mail Order:** 90-day supply Generic - $5 Preferred brand - $15 Other brands - $25	Generic - copayment $5 Preferred brand - $10 Other brands - $20 **Mail Order:** 90-day supply Generic - $5 Preferred brand - $15 Other brands - $25	Generic - copayment $5 Preferred brand - $10 Other brands - $20 **Mail Order:** 90-day supply Generic - $15 Name brand - $30	Generic - copayment $5 Preferred brand - $10 Other brands - $20 **Mail Order:** 90-day supply Generic - $5 Preferred brand - $15 Other brands - $25	Generic - copayment $5 Preferred brand - $10 Other brands - $20 **Mail Order:** 90-day supply Generic - $5 Preferred brand - $15 Other brands - $25	Generic - copayment $5 Preferred brand - $10 Other brands - $20 **Mail Order:** 90-day supply Generic - $5 Preferred brand - $15 Other brands - $25	**PRESCRIPTION DRUGS[7]** ***RETIREE***
ROUTINE VISION EXAM	None	100% after $5 copayment; one exam per calendar year; no referral needed	None	100% after $5 copayment; exam every 2 years; no referral needed	100% after $5 copayment; one exam per calendar year; referral required	$50 reimbursed toward routine exam per 12 month period	100% after $5 copayment; one exam every 24 month period; must use specified vendor, no referral needed	100% after $5 copayment; one exam per calendar year; no referral needed	100% after $5 copayment; one exam per calendar year; must use specified vendor, no referral needed	**ROUTINE VISION EXAM**
RETIREE/EMPLOYEE SHARE OF COSTS										**RETIREE/EMPLOYEE SHARE OF COSTS**
DEDUCTIBLES (INDIVIDUAL)	$100 per calendar year (medical expenses only)	None	$100 per calendar year (most expenses); $200 per hospital admission	None	None	None	None	None	None	**DEDUCTIBLES (INDIVIDUAL)**
DEDUCTIBLES (FAMILY MAXIMUM)	Employee and/or retiree plus one dependent must meet individual deductible	None	$250 per calendar year (most expenses); $200 per hospital admission	None	None	None	None	None	None	**DEDUCTIBLES (FAMILY MAXIMUM)**
MAXIMUM OUT-OF-POCKET (INDIVIDUAL)	$400 per calendar year coinsurance + $100 deductible	$400 per calendar year (coinsurance only)	$2,000 per calendar year (coinsurance only)	No maximum	$1,500 per calendar year (sum of copayments)	No maximum	$650 per calendar year (sum of copayments)	$2,700 per calendar year (sum of copayments)	No maximum	**MAXIMUM OUT-OF-POCKET (INDIVIDUAL)**
MAXIMUM OUT-OF-POCKET (FAMILY)	$400 X number of dependents + deductible	$1,000 per calendar year (coinsurance only)	$5,000 per calendar year (coinsurance only)	No maximum	$3,000 per calendar year (sum of copayments)	No maximum	$650 per person per calendar year (sum of copayments), then 100%	$5,400 per calendar year (sum of copayments), then 100%	No maximum	**MAXIMUM OUT-OF-POCKET (FAMILY)**
MAXIMUM PLAN COVERED EXPENSES ANNUAL/LIFETIME	$1,000,000 lifetime (major medical expense only); $10,000 annual mental health - $20,000 lifetime mental health; up to $2,000 restoration feature each year[4]	Unlimited; $15,000 annual mental health; $50,000 lifetime mental health; up to $2,000 restoration feature each year[4]	$1,000,000 lifetime (major medical expense only); $15,000 annual mental health; $50,000 lifetime mental health; up to $2,000 restoration feature each year[4]	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	**MAXIMUM PLAN COVERED EXPENSES ANNUAL/LIFETIME**
PLAN AND TELEPHONE NUMBER	**#002 TRADITIONAL[1] (800) 414-7427**	**#001 - NJ PLUS In-Network (800) 414-7427**	**#001 - NJ PLUS Out-of-Network[1] (800) 414-7427**	**#019 - AETNA- US HEALTHCARE Active (800) 309-2386 Retiree on Medicare (800) 345-4432**	**#020 CIGNA HEALTHCARE (800) 832-3211**	**#028 OXFORD (800) 444-6222**	**#033 AMERIHEALTH (800) 877-9829**	**#034 HEALTH NET[2] (800) 535-3647**	**#036 - UNIVERSITY HEALTH PLANS (800) 564-6847**	**PLAN AND TELEPHONE NUMBER**

[1]Benefits, excluding hospital expenses, are based on the Horizon's PACE allowance or the "reasonable and customary" fee schedule at the 90% percentile.

[2]Health Net referral is not required from a PCP to a participating specialist.

[3]Most plans require notice to the PCP within 48 hours of the incident. Copayment waived if admitted.

[4]Biologically-based mental health conditions are treated like any other illness and not subject to annual or lifetime mental health dollar maximums or separate mental health visit limits.

[5]Speech therapy limited to: restoration after a loss or impairment of a demonstrated previous ability to speak; develop or improve speech after surgical correction of a birth defect.

[6]If your employer provides a separate prescription drug plan to employees, the medical plan will not include any drug coverage. If no separate prescription drug plan is provided, the medical plan will provide drug coverage as noted.

[7]Certain prescription drugs may require precertification prior to purchase. Please contact your health plan for details.

[8]Maximum copayments per member are $345 per year.